



**Kaiser Foundation Health Plan, Inc.
Southern California Region**

A nonprofit corporation

EOC #131 - Kaiser Permanente Traditional HMO Plan Evidence of Coverage for SISC-SELF INSURED SCHOOLS OF CALIFORNIA

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Member Service Contact Center
24 hours a day, seven days a week (except closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجى الاتصال على الرقم (711).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週7天，每天24小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週7天，每天24小時均歡迎您打電話**1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線 (TTY) 使用者請撥**711**。

Farsi: خدمات زبانی در 24 ساعت شبانه روز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کفایت در 24 ساعت شبانه روز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बनिा कसिी लागत के दुभाषया सेवाएँ, दनि के 24 घंटे, सप्ताह के सातों दनि उपलब्ध हैं। आप एक दुभाषया की सेवाओं के लिए, बनिा कसिी लागत के सामग्रयिों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पकि परारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दनि के 24 घंटे, सप्ताह के सातों दनि (छुट्टयिों वाले दनि बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkw pab txhais lus pub dawb rau koj, 24 teev ib hnuv twg, 7 hnuv ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnuv twg, 7 hnuv ib lim tiam twg (cov hnuv caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTYユーザーは**711**にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទម្រង់ផ្សេងទៀត។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000**번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມາດໃຫ້ໂດຍບໍ່ເສັຽຄ່າແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານສາມາດຮ້ອງຂໍບໍລິການນາຍພາສາ, ໃຫ້ແປອອກສາລະຄົມພາສາຂອງທ່ານ, ຫຼືໃບຮູບແບບອື່ນ. ພາສາຕາໂທສຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ບໍ່ວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທສ **711**.

Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibaa' dji' ahéé'iikeed tsosts'id yiskáají damoo ná'ádleejji. Atah halne'é áká'adoolwołigíí jókí, t'áadoo le'é t'áá hóhazaadjí hadilyaa'go, éí doodaii' nááná lá al'aa ádaat'ehígíí bee hádadilyaa'go. Kojí hodiilnih **1-800-464-4000**, naadiin doo bibaa' dji' ahéé'iikeed tsosts'id yiskáají damoo ná'ádleejji (Dahodiyin biniyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojí hodiilnih **711**.

Punjabi: ਬਨਿੰ ਕਮਿ ਲਾਗਤ ਦੇ, ਦਨਿ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਨਿ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਮਿ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਰਿਫ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਨਿ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਨਿ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਨਿ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 ชั่วโมงทุกวันตลอดชั่วโมงทำการของเรา คุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวข้องกับความคุ้มครองการดูแลสุขภาพของเรา และคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีค่าบริการ เพียงโทรหาเราที่หมายเลข **1-800-464-4000** ตลอด 24 ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ **711**.

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Service Contact Center 24 hours a day, 7 days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language at no cost to you. You may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call **1-800-464-4000** (TTY 711).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance* or speak with a Member Services representative for the dispute-resolution options that apply to you.

You may submit a grievance in the following ways:

- **By phone:** Call member services at **1-800-464-4000** (TTY 711) 24 hours a day, 7 days a week (except closed holidays).
- **By mail:** Call us at **1-800-464-4000** (TTY 711) and ask to have a form sent to you.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)
- **Online:** Use the online form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at:

Northern California

Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California

Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH

Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://www.hhs.gov/ocr/office/file/index.html).

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los 7 días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma sin costo para usted. También los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al **1-800-788-0616** (TTY **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura* (*Evidence of Coverage*) o *Certificado de Seguro* (*Certificate of Insurance*), o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden.

Puede presentar una queja de las siguientes maneras:

- **Por teléfono:** Llame a servicio a los miembros al **1-800-788-0616** (TTY **711**) las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- **Por correo postal:** Llámenos al **1-800-788-0616** (TTY **711**) y pida que se le envíe un formulario.
- **En persona:** Llene un formulario de Queja Formal o Reclamo/Solicitud de Beneficios en una oficina de servicio a los miembros ubicada en un Centro de Atención del Plan (consulte su directorio de proveedores en **kp.org/facilities**[haga clic en “Español”] para obtener las direcciones).
- **En línea:** Use el formulario en línea en nuestro sitio web en **kp.org/espanol**.

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al Coordinador de Derechos Civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en:

Northern California

Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California

Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el Portal de Quejas Formales de la Oficina de Derechos Civiles (Office for Civil Rights Complaint Portal), en ocrportal.hhs.gov/ocr/portal/lobby.jsf (en inglés) o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Los formularios de queja formal están disponibles en hhs.gov/ocr/office/file/index.html (en inglés).

無歧視公告

Kaiser Permanente禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週7天每天24小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯服務，包括手語服務，以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您可免費索取翻譯成您的語言的資料。您還可免費索取符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電**1-800-757-7585**（TTY 711）。

申訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出申訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》(Evidence of Coverage)或《保險證明書》(Certificate of Insurance)，或諮詢會員服務代表。

您可透過以下方式提出申訴：

- **透過電話：**請致電**1-800-757-7585**（TTY 711）與會員服務部聯絡，服務時間為每週7天，每天24小時（節假日除外）。
- **透過郵件：**請致電**1-800-757-7585**（TTY 711）與我們聯絡並請我們將表格寄給您。
- **親自遞交：**在計劃設施的會員服務辦事處填寫投訴或福利理索賠 / 申請表（請參閱 kp.org/facilities 上的保健業者名錄以查看地址）
- **線上：**使用我們網站上的線上表格，網址為 kp.org

如果您在提交申訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知Kaiser Permanente的民權事務協調員 (Civil Rights Coordinator)。您也可與Kaiser Permanente的民權事務協調員直接聯絡，地址：

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

您還可以電子方式透過民權辦公室的投訴入口網站 (Office for Civil Rights Complaint Portal) 向美國衛生與民眾服務部 (U.S. Department of Health and Human Services) 民權辦公室 (Office for Civil Rights) 提出民權投訴，網址是 ocrportal.hhs.gov/ocr/portal/lobby.jsf 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY)。投訴表可從網站 hhs.gov/ocr/office/file/index.html 下載。

Thông Báo Không Kỳ Thị

Kaiser Permanente không phân biệt đối xử dựa trên tuổi tác, chủng tộc, sắc tộc, màu da, nguyên quán, hoàn cảnh văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng tình dục, gia cảnh, khuyết tật về thể chất hoặc tinh thần, nguồn tiền thanh toán, thông tin di truyền, quốc tịch, ngôn ngữ chính, hay tình trạng di trú.

Các dịch vụ trợ giúp ngôn ngữ hiện có từ Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ ngày lễ). Dịch vụ thông dịch, kể cả ngôn ngữ ký hiệu, được cung cấp miễn phí cho quý vị trong giờ làm việc. Các phương tiện trợ giúp và dịch vụ bổ sung cho những người khuyết tật được cung cấp miễn phí cho quý vị trong giờ làm việc. Chúng tôi cũng có thể cung cấp cho quý vị, gia đình và bạn bè quý vị mọi hỗ trợ đặc biệt cần thiết để sử dụng cơ sở và dịch vụ của chúng tôi. Quý vị có thể yêu cầu miễn phí tài liệu được dịch ra ngôn ngữ của quý vị. Quý vị cũng có thể yêu cầu miễn phí các tài liệu này dưới dạng chữ lớn hoặc dưới các dạng khác để đáp ứng nhu cầu của quý vị. Để biết thêm thông tin, gọi **1-800-464-4000 (TTY 711)**.

Một phần này là bất cứ thể hiện bất mãn nào được quý vị hay vị đại diện được ủy quyền của quý vị trình bày qua thủ tục phàn nàn. Ví dụ, nếu quý vị tin rằng chúng tôi đã kỳ phân biệt đối xử với vị, quý vị có thể đệ đơn phàn nàn. Vui lòng tham khảo *Chứng Từ Bảo Hiểm (Evidence of Insurance)* hay *Chứng Nhận Bảo Hiểm (Certificate of Insurance)*, hoặc nói chuyện với một nhân viên ban Dịch Vụ Hội Viên để biết các lựa chọn giải quyết tranh chấp có thể áp dụng cho quý vị.

Quý vị có thể nộp đơn phàn nàn bằng các hình thức sau đây:

- **Qua điện thoại:** Gọi cho ban dịch vụ hội viên theo số **1-800-464-4000 (TTY 711)** 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ đóng cửa ngày lễ).
- **Qua bưu điện:** Gọi cho chúng tôi theo số **1-800-464-4000 (TTY 711)** và yêu cầu được gửi một mẫu đơn.
- **Trực tiếp:** Điền một mẫu đơn Than Phiền hay Yêu Cầu Quyền Lợi/Yêu Cầu tại một văn phòng ban dịch vụ hội viên tại một Cơ Sở Thuộc Chương Trình (xem danh mục nhà cung cấp của quý vị tại **kp.org/facilities** để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại **kp.org**

Xin gọi Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi nếu quý vị cần trợ giúp nộp đơn phàn nàn.

Điều Phối Viên Dân Quyền (Civil Rights Coordinator) Kaiser Permanente sẽ được thông báo về tất cả phàn nàn liên quan tới việc kỳ thị trên cơ sở chủng tộc, màu da, nguyên quán, giới tính, tuổi tác, hay tình trạng khuyết tật. Quý vị cũng có thể liên lạc trực tiếp với Điều Phối Viên Dân Quyền Kaiser Permanente tại:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

Quý vị cũng có thể đệ đơn than phiền về dân quyền với Bộ Y Tế và Nhân Sinh Hoa Kỳ (U.S. Department of Health and Human Services), Phòng Dân Quyền (Office of Civil Rights) bằng đường điện tử thông qua Cổng Thông Tin Phòng Phụ Trách Khiếu Nại về Dân Quyền (Office for Civil Rights Complaint Portal), hiện có tại ocrportal.hhs.gov/ocr/portal/lobby.jsf, hay bằng đường bưu điện hoặc điện thoại tại: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Mẫu đơn than phiền hiện có tại hhs.gov/ocr/office/file/index.html.

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Cost Share Summary

This “Cost Share Summary” is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductible(s) and Out-of-Pocket Maximum(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Deductible	None	None	None
Drug Deductible	None	None	None
Plan Out-of-Pocket Maximum (“OOPM”)	\$1,500	\$1,500	\$3,000

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, please refer to the same benefit heading in the “Benefits” section of this *EOC*.

- **Copayment / Coinsurance.** This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the “Deductible(s) and Out-of-Pocket Maximum(s)” section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read “Not covered.” If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible.** This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a “✓” or “●” in this column, depending on which deductible applies (“✓” for Plan Deductible, “●” for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, please refer to “Plan Deductible” and “Drug Deductible” in the “Benefits” section of this *EOC*.
- **OOPM.** This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum (“OOPM”) after you have met any applicable deductible. If the Services count toward the Plan OOPM, there will be a “✓” in this column. If the Services do not count toward the Plan OOPM, this column will be blank. For a more detailed explanation of the Plan OOPM, please refer to “Plan Out-of-Pocket Maximum” heading in the “Benefits” section of this *EOC*.

Administered drugs and products

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Whole blood, red blood cells, plasma, and platelets	No charge		✓
Allergy antigens (including administration)	No charge		✓
Cancer chemotherapy drugs and adjuncts	No charge		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products (“biologics”) derived from tissue, cells, or blood	No charge		✓
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Emergency ambulance Services	\$50 per trip		✓
Nonemergency ambulance and psychiatric transport van Services	\$50 per trip		✓

Behavioral health treatment for autism spectrum disorder

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Covered Services	\$15 per day		✓

Dialysis care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge		✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	\$15 per visit		✓

Durable Medical Equipment (“DME”) for home use

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Blood glucose monitors for diabetes blood testing and their supplies	No charge		✓
Peak flow meters	No charge		✓
Insulin pumps and supplies to operate the pump	No charge		✓
Other Base DME Items as described in this <i>EOC</i>	No charge		✓
Supplemental DME items as described in this <i>EOC</i>	No charge		
Retail-grade breast pumps	No charge		✓
Hospital-grade breast pumps	No charge		✓

Emergency and Urgent Care visits

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Emergency Department visits	\$100 per visit		✓
Urgent Care visits	\$15 per visit		✓

Note: If you are admitted to the hospital as an inpatient from the Emergency Department, the Emergency Department visits Cost Share above does not apply. Instead, the Services you received in the Emergency Department, including any observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, please refer to “Hospital inpatient care” in this “Cost Share Summary.” The Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Family planning Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Family planning counseling	No charge		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (“IUDs”) and office visits related to their administration and management	No charge		✓
Female sterilization procedures if performed in an ambulatory surgery center or in a hospital operating room	No charge		✓
All other female sterilization procedures	No charge		✓
Male sterilization procedures if performed in an ambulatory surgery center or in a hospital operating room	\$15 per procedure		✓
All other male sterilization procedures	\$15 per visit		✓
Termination of pregnancy	\$15 per procedure		✓

Fertility Services

Diagnosis and treatment of infertility

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Office visits	\$15 per visit		
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	\$15 per procedure		
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	\$15 per procedure		
Outpatient imaging	No charge		
Outpatient laboratory	No charge		
Outpatient diagnostic Services	No charge		
Outpatient administered drugs	No charge		

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	No charge		

Artificial insemination

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Office visits	\$15 per visit		
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	\$15 per procedure		
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	\$15 per procedure		
Outpatient imaging	No charge		
Outpatient laboratory	No charge		
Outpatient diagnostic Services	No charge		
Outpatient administered drugs	No charge		
Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	No charge		

Assisted reproductive technology (“ART”) Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Assisted reproductive technology (“ART”) Services such as invitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), or zygote intrafallopian transfer (“ZIFT”)	Not covered		

Health education

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to smoking cessation	No charge		✓
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Hearing exams with an audiologist to determine the need for hearing correction	\$15 per visit		✓
Physician Specialist Visits to diagnose and treat hearing problems	\$15 per visit		✓
Hearing aid(s), including, fitting, counseling, adjustment, cleaning, and inspection	A \$500 Allowance for each ear every 36 months		

Home health care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Home health care Services (100 visits per Accumulation Period)	No charge		✓

Hospice care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Hospice Services	No charge		✓

Hospital inpatient care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Inpatient hospital stays	No charge		✓

Injury to teeth

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Inpatient mental health hospital stays	No charge		✓
Individual mental health evaluation and treatment	\$15 per visit		✓
Group mental health treatment	\$7 per visit		✓
Partial hospitalization	No charge		✓
Other intensive psychiatric treatment programs	No charge		✓
Residential mental health treatment Services	No charge		✓

Office visits

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	\$15 per visit		✓
Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	\$15 per visit		✓
Group appointments that are not described elsewhere in this “Cost Share Summary”	\$7 per visit		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Acupuncture Services	\$15 per visit		✓
House calls Note: Effective January 1, 2022, the Cost Share for house calls will be the Cost Share listed above for Primary Care Visits, Non-Physician Specialist Visits, or Physician Specialist Visits, as applicable.	No charge		✓

Ostomy and urological supplies

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Ostomy and urological supplies as described in this <i>EOC</i>	No charge		✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	No charge		✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	No charge		✓
Nuclear medicine	No charge		✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge		✓
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	No charge		✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	No charge		✓
Radiation therapy	No charge		✓
Ultraviolet light treatments	No charge		✓

Outpatient prescription drugs, supplies, and supplements

If the “Cost Share at a Plan Pharmacy” column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Items on the generic tier not described elsewhere in this “Cost Share Summary”	\$5 for up to a 30-day supply	\$10 for up to a 100-day supply		✓
Items on the brand tier not described elsewhere in this “Cost Share Summary”	\$20 for up to a 30-day supply	\$40 for up to a 100-day supply		✓
Items on the specialty tier not described elsewhere in this “Cost Share Summary”	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Base drugs, supplies, and supplements

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓
All other items on the generic tier as described in this <i>EOC</i>	\$5 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on the brand tier as described in this <i>EOC</i>	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on the specialty tier as described in this <i>EOC</i>	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Oral anticancer drugs on the generic tier	\$5 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on the brand tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on the specialty tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the generic tier	\$5 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the brand tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the specialty tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Home infusion drugs

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available		✓
Supplies necessary for administration of home infusion drugs	No charge	No charge		✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Diabetes supplies and amino acid–modified products

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available		✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	\$5 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, please refer to the “Most items” table above. For insulin pumps, please refer to the “Durable Medical Equipment (“DME”) for home use” table above.

Contraceptive drugs and devices

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
The following hormonal contraceptive items for women on the generic tier when prescribed by a Plan Provider: <ul style="list-style-type: none"> • Rings • Patches • Oral contraceptives 	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		✓
The following contraceptive items for women on the generic tier when prescribed by a Plan Provider: <ul style="list-style-type: none"> • Female condoms • Spermicide • Sponges 	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items for women on the brand tier when prescribed by a Plan Provider: <ul style="list-style-type: none"> • Rings • Patches • Oral contraceptives 	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		✓

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
The following contraceptive items for women on the brand tier when prescribed by a Plan Provider: <ul style="list-style-type: none"> • Female condoms • Spermicide • Sponges 	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms and cervical caps	No charge	Not available		✓

Certain preventive items

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Items on our Preventive Services list on our website at kp.org/prevention when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓

Fertility and sexual dysfunction drugs

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Drugs on the generic tier prescribed to treat infertility or in connection with covered artificial insemination Services	\$5 for up to a 30-day supply	\$10 for up to a 100-day supply		
Drugs on the brand and specialty tiers prescribed to treat infertility or in connection with covered artificial insemination Services	\$20 for up to a 30-day supply	\$40 for up to a 100-day supply		
Drugs on the generic tier prescribed in connection with covered assisted reproductive technology (“ART”) Services	Not covered	Not covered		
Drugs on the brand and specialty tiers prescribed in connection with covered assisted reproductive technology (“ART”) Services	Not covered	Not covered		

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Drugs on the generic tier prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed \$50) for up to a 100-day supply	50% Coinsurance (not to exceed \$50) for up to a 100-day supply		✓
Drugs on the brand and specialty tiers prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed \$100) for up to a 100-day supply	50% Coinsurance (not to exceed \$100) for up to a 100-day supply		✓

Outpatient surgery and outpatient procedures

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	\$15 per procedure		✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	\$15 per procedure		✓

Preventive Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Routine physical exams, including well-woman and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
First postpartum follow-up consultation and exam	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Tuberculosis skin tests	No charge		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection (“STI”) tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Internally implanted prosthetic and orthotic devices as described in this <i>EOC</i>	No charge		✓
External prosthetic and orthotic devices as described in this <i>EOC</i>	No charge		✓
Supplemental prosthetic and orthotic devices as described in this <i>EOC</i>	No charge		✓

Rehabilitative and habilitative Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Individual outpatient physical, occupational, and speech therapy	\$15 per visit		✓
Group outpatient physical, occupational, and speech therapy	\$7 per visit		✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	\$15 per day		✓

Skilled nursing facility care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Skilled nursing facility Services up to 100 days per benefit period*	No charge		✓

*A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Substance use disorder treatment

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Inpatient detoxification	No charge		✓
Individual substance use disorder evaluation and treatment	\$15 per visit		✓
Group substance use disorder treatment	\$5 per visit		✓
Intensive outpatient and day-treatment programs	\$5 per day		✓
Residential substance use disorder treatment	No charge		✓

Telehealth visits

Interactive video visits

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Physician Specialist Visits	No charge		✓

Scheduled telephone visits

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Vision Services for Adult Members

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	\$15 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	\$15 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	\$15 per visit		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	\$15 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Introduction

This *Evidence of Coverage* (“*EOC*”) describes the health care coverage of “Kaiser Permanente Traditional HMO Plan” provided under the *Group Agreement* (“*Agreement*”) between Kaiser Foundation Health Plan, Inc. (“Health Plan”) and the entity with which Health Plan has entered into the *Agreement* (your “Group”).

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan’s evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group’s materials.

In this *EOC*, Health Plan is sometimes referred to as “we” or “us.” Members are sometimes referred to as “you.” Some capitalized terms have special meaning in this *EOC*; please see the “Definitions” section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your “Home Region.” The

coverage information in this *EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the “Definitions” section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under “Getting a Referral” in the “How to Obtain Services” section
- Emergency ambulance Services as described under “Ambulance Services” in the “Benefits” section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the “Emergency Services and Urgent Care” section
- Hospice care as described under “Hospice Care” in the “Benefits” section
- Visiting Member Services as described under “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section

Term of this EOC

This *EOC* is for the period October 1, 2021, through September 30, 2022, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this “Definitions” section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Adult Member: A Member who is age 19 or older and is not a Pediatric Member. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the item(s) you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC*. If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: “Charges” means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan’s schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member’s benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program’s contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*.

Note: The dollar amount of the Copayment can be \$0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see “Who Is Eligible” in the “Premiums, Eligibility, and Enrollment” section).

Disclosure Form (“DF”): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Please refer to the “Cost Share Summary” section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

- Placing the person’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

EOC: This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of “Kaiser Permanente Traditional HMO Plan” under Health Plan’s *Agreement* with your Group.

Family: A Subscriber and all of their Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *EOC* sometimes refers to Health Plan as “we” or “us.”

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

Medically Necessary: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, a Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as “you.”

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under “Dental and Orthodontic Services” in the “Benefits” section, non-physician specialists include dentists and orthodontists.

Non-Plan Hospital: A hospital other than a Plan Hospital.

Non-Plan Physician: A physician other than a Plan Physician.

Non-Plan Provider: A provider other than a Plan Provider.

Non-Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child’s) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child’s) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Pediatric Member: A Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Please refer to the “Cost Share Summary” section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at kp.org/facilities. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Plan Hospital: Any hospital listed in the Provider Directory on our website at kp.org/facilities. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call our Member Service Contact Center.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at kp.org/facilities. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called “Vision Essentials.” The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Please refer to the “Cost Share Summary” section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website

at kp.org/facilities for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call our Member Service Contact Center.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC*, except that you are responsible for paying Premiums if you have Cal-COBRA coverage. “Full Premiums” means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the “Premiums” section of Health Plan’s *Agreement* with your Group.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at kp.org for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at kp.org/facilities. To obtain a

printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at kp.org or call our Member Service Contact Center.

Service Area: The ZIP codes below for each county are in our Service Area:

- The following ZIP codes in Imperial County are inside our Service Area: 92274-75
- The following ZIP codes in Kern County are inside our Service Area: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- The following ZIP codes in Los Angeles County are inside our Service Area: 90001-84, 90086-91, 90093-96, 90099, 90134, 90189, 90201-02, 90209-13, 90220-24, 90230-33, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91526, 91601-12, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- All ZIP codes in Orange County are inside our Service Area: 90620-24, 90630-33, 90638, 90680,

90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711-12, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92850, 92856-57, 92859, 92861-71, 92885-87, 92899

- The following ZIP codes in Riverside County are inside our Service Area: 91752, 92028, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
- The following ZIP codes in San Bernardino County are inside our Service Area: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 91792, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in San Diego County are inside our Service Area: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99
- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261
- The following ZIP codes in Ventura County are inside our Service Area: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in our Service Area, please call our Member Service Contact Center.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items (“health care” includes both physical health care and mental health care), and behavioral health treatment covered under “Behavioral Health Treatment for Autism Spectrum Disorder” in the “Benefits” section.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility’s primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term “Skilled Nursing Facility” does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A “Skilled Nursing Facility” may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term “Spouse” includes the Subscriber’s domestic partner. “Domestic partners” are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, “Spouse” also includes the Subscriber’s domestic partner who meets your Group’s eligibility requirements for domestic partners).

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), “Stabilize” means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see “Who Is Eligible” in the “Premiums, Eligibility, and Enrollment” section).

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Full Premiums, except that you are responsible for paying Full Premiums as described in the “Continuation of Membership” section if you have Cal-COBRA coverage under this *EOC*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this “Who Is Eligible” section, including your Group’s eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group’s eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

The “Definitions” section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) they live inside or move to the service area of another Region and do not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

Dependent children of the Subscriber or of the Subscriber’s Spouse may live anywhere inside or outside our Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another

Region, please contact your Group to learn about your Group health care options:

- **Regions outside California.** You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Northern California Region's service area.** Your Group may have an arrangement with us that permits membership in the Northern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Southern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the service areas of the other Regions, please call our Member Service Contact Center.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
 - ◆ sons, daughters, or stepchildren
 - ◆ adopted children

- ◆ children placed with you for adoption, but not including children placed with you for foster care
- ◆ children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Certain Dependents may continue their memberships for a limited time after membership would otherwise terminate as a result of the Subscriber's death if permitted by your Group (please ask your Group for details)

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth), or until the date the baby is enrolled in other coverage, whichever happens first.

Age limit of Dependent children

Children must be under age 26 as of the effective date to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- You give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification

One of the requirements for a Dependent to be eligible to continue coverage as a disabled Dependent is that the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Members with Medicare and retirees

This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *EOC* if permitted by your Group (please ask your Group for details).

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *EOC* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of

Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of adoption.

Special enrollment due to loss of other coverage

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
 - ◆ exhaustion of COBRA coverage
 - ◆ termination of employer contributions for non-COBRA coverage
 - ◆ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan’s service area, reaching the age limit for dependent children, or the subscriber’s death, termination of employment, or reduction in hours of employment
 - ◆ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children’s Health Insurance Program coverage, or Medi-Cal Access Program coverage
 - ◆ reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for

submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children’s Health Insurance Program, or Medi-Cal Access Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order

Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group’s health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service

If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group’s health plan if required by state or federal law. Please ask your Group for more information.

Other special enrollment events

You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add

eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
 - ◆ a qualified individual was not enrolled in a qualified health plan
 - ◆ a qualified individual was not enrolled in the qualified health plan that the individual selected
 - ◆ a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

Note: If you are enrolling as a Subscriber along with at least one eligible Dependent, only one of you must meet one of the requirements stated above.

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under “Getting a Referral” in this “How to Obtain Services” section
- Emergency ambulance Services as described under “Ambulance Services” in the “Benefits” section

- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the “Emergency Services and Urgent Care” section
- Hospice care as described under “Hospice Care” in the “Benefits” section
- Visiting Member Services as described under “Receiving Care Outside of Your Home Region” in this “How to Obtain Services” section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, please refer to our Provider Directory or call our Member Service Contact Center. To request an appointment online, go to our website at kp.org.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, please refer to our Provider Directory or call our Member Service Contact Center.

For information about Out-of-Area Urgent Care, please refer to “Urgent Care” in the “Emergency Services and Urgent Care” section.

Not Sure What Kind of Care You Need?

Sometimes it’s difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven

days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside our Service Area

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call our Member Service Contact Center). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under “Preventive Services” in the “Benefits” section.

To learn how to select or change to a different personal Plan Physician, visit our website at kp.org or call our Member Service Contact Center. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians

may change. If you have questions, please call our Member Service Contact Center. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get care from Qualified Autism Service Providers covered under “Behavioral Health Treatment for Autism Spectrum Disorder” in the “Benefits” section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with “Medical Group authorization procedure for certain referrals” in this “Getting a Referral” section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to

be covered (“prior authorization” means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management (“UM”) is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Service Contact Center to request a printed copy.

Please refer to “Post-Stabilization Care” under “Emergency Services” in the “Emergency Services and Urgent Care” section for authorization requirements that apply to Post-Stabilization Care from Non-Plan Providers.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this “Medical Group authorization procedure for certain referrals” section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group’s designee Plan Physician, who will make an authorization decision as described under “Medical Group’s decision time frames”

in this “Medical Group authorization procedure for certain referrals” section.

Medical Group’s decision time frames

The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn’t have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or specialist that is needed, and the date that the Medical Group expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under “Grievances” in the “Dispute Resolution” section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Travel and lodging for certain referrals

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside our Service Area for certain specialty Services such as a transplant or transgender surgery

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, please refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

Completion of Services from Non-Plan Providers

New Member

If you are currently receiving Services from a Non-Plan Provider in one of the cases listed below under “Eligibility” and your prior plan’s coverage of the provider’s Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non-Plan Provider’s Services.

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under “Eligibility” from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider’s Services.

Eligibility

The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non-Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
 - ◆ it persists without full cure

- ◆ it worsens over an extended period of time
- ◆ it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child’s effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child’s third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Services
- For new Members, your prior plan’s coverage of the provider’s Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non-Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider’s termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non-Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area (the requirement that the provider agree to

providing Services inside our Service Area doesn't apply if you were receiving covered Services from the provider outside the Service Area when the provider's contract terminated)

- The Services to be provided to you would be covered Services under this *EOC* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information

For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Contact Center.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non-Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition

- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please visit our website at kp.org or call our Member Service Contact Center.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non-Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; please refer to "Completion of Services from Non-Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals

If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles

of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Receiving Care Outside of Your Home Region

If you have questions about your coverage when you are away from home, call the Away from Home Travel line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). For example, call this number for the following concerns:

- What you should do to prepare for your trip
- What Services are covered when you are outside our Service Area
- How to get care in another Region
- How to request reimbursement if you paid for covered Services outside our Service Area

You can also get information on our website at kp.org/travel.

Receiving care in the Service Area of another Region

If you are visiting in the service area of another Region, you may receive Visiting Member Services from designated providers in that Region. “Visiting Member Services” are Services that are covered under your Home Region plan that you receive in another Region, subject to exclusions, limitations, prior authorization or approval requirements, and reductions described in this *EOC* or the Visiting Member Brochure, which is available online at kp.org. Certain Services are not covered as Visiting Member Services. For more information about receiving Visiting Member Services in another Region, including provider and facility locations, or to obtain a copy of the Visiting Member Brochure, please call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). Information is also available online at kp.org/travel.

For Visiting Member Services, you pay the Cost Share required for Services provided by a Plan Provider inside our Service Area as described in this *EOC*.

Receiving care outside of any Region

If you are traveling outside of a Kaiser Permanente Region, we cover Emergency Services and Urgent Care as described in the “Emergency Services and Urgent Care” section.

Your ID Card

Each Member’s Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call our Member Service Contact Center if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under “Termination for Cause” in the “Termination of Membership” section.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care (“DMHC”) developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent Care: within 48 hours
- Nonurgent Primary Care Visit or Non-Physician Specialist Visit: within 10 business days
- Physician Specialist Visit: within 15 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won’t have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. The standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, 7 days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call our Member Service Contact Center.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (except closed holidays)

Visit Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Write Member Services Department at a Plan Facility (for addresses, refer to our Provider

Directory or call our Member Service Contact Center)

Website **kp.org**

Cost Share estimates

For information about estimates, see “Getting an estimate of your Cost Share” under “Your Cost Share” in the “Benefits” section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments (for Emergency Department locations, refer to our Provider Directory or call our Member Service Contact Center)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call our Member Service Contact Center)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (for locations, refer to our Provider Directory or call our Member Service Contact Center)

Note: State law requires evidence of coverage documents to include the following notice:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning;

contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Contact Center, to ensure that you can obtain the health care services that you need.

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from a hospital, and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see “Durable Medical Equipment (“DME”) for Home Use” in the “Benefits” section. We cover Post-Stabilization Care from a Non-Plan Provider only if we provide prior authorization for the care or if otherwise required by applicable law (“prior authorization” means that we must approve the Services in advance).

To request prior authorization, the Non-Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non-Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non-Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non-Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non-Plan Providers that has not been authorized. If you receive care from a Non-Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non-Plan Hospital, please notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the “Cost Share Summary” section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non-Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non-Plan Hospital, you pay the Cost Share for an Emergency Department visit as described in the “Cost Share Summary” under “Emergency and Urgent Care visits”
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non-Plan Hospital, you pay the Cost Share for hospital inpatient care as described in the “Cost Share Summary” under “Hospital inpatient care”
- If we gave prior authorization for durable medical equipment after discharge from a Non-Plan Hospital, you pay the Cost Share for durable medical equipment as described in the “Cost Share Summary” under “Durable Medical Equipment (“DME”) for home use”

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If

you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non-Plan Provider if all of the following are true:

- You receive the Services from Non-Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non-Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center. We do not cover follow-up care from Non-Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Getting a Referral" in the "How to Obtain Services" section.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the "Cost Share Summary" section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non-Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency and Urgent Care visits"

- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described in the "Cost Share Summary" under "Emergency and Urgent Care visits."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non-Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits" section, you are not responsible for any amounts beyond your Cost Share for covered Emergency Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non-Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.